

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/23/2011
NAME OF PROVIDER OR SUPPLIER  NORTHSIDE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 157 SS=D	<p>During complaint investigation for complaints TN 28487 and TN 27609, conducted on 8/23/2011, no deficiencies were cited for TN 27609.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157 SS=D	<p>9/20/11 acceptable mad</p> <p><u>Description</u></p> <p>483.10(b)(11) Notify of Changes (injury/ decline/ room, etc)</p> <p>The facility must notify the family/ legal representative and the physician in changes with the patient.</p> <p><u>Corrective Action</u></p> <ol style="list-style-type: none"> <li>1. Physician was notified of the medication error on patient # 3 from 07/25/11 on 08/23/11 by the ADON. Family was notified of the medication change on 7/21/11 during a scheduled family meeting.</li> <li>2. Charts were audited on 8/24 thru 8/26 by DON and ADON to ensure other patients were not being affected by this practice.</li> <li>3. DON and ADON in-serviced nursing staff on notification of family and physician on 08/24/11 during a special called licensed nursing meeting.</li> <li>4. DON, ADON and weekend supervisor will monitor for compliance during daily chart audits by reviewing new physician orders and occurrences and will record results on audit tool. 100% will be audited for 30 days or until substantial compliance is obtained and will then decrease to 25% for an additional 60 days.</li> <li>5. Findings will be reported to the QA Committee who will review finding and set new interventions and goals as needed. The QA Committee consist of Medical Director, Administrator, DON, ADON, MDS Coordinator.</li> </ol>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the family for changes of condition/treatment, and notify the physician of a medication error for one (#3) of seven residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #3 was admitted to the facility on July 13, 2011 with diagnoses to include Diabetes Mellitus, Rheumatoid Arthritis, Anemia, Osteoporosis, and Anxiety.</p> <p>Review of an admission nursing assessment revealed the resident was oriented to person and place; required assistance with transfers, bathing, dressing, and grooming; was continent of bowel and bladder; was independent with eating; and used a rolling walker for ambulation.</p> <p>Review of transfer/admission orders dated July 13, 2011, revealed the resident was ordered Fentanyl (narcotic pain reliever) patch 25 mcg (micrograms) to be changed every three days as well as Lortab (pain reliever) 25/500 mg (milligrams) 1 tablet every 4 hours as needed for pain.</p> <p>Review of physician's orders dated July 15, 2011, the resident was ordered Fentanyl patch 50 mcg to be changed every three days. Review of physician's orders dated July 20, 2011, revealed "Lortab 5/325 mg every 4-6 hours as needed". Continued review of physician's orders dated July</p>	F 157	<p>Medical Records, Social, Activities, Food Service Supervisor, RD, Bookkeeping, Payroll, Maintenance and Environmental Services.</p>		09/14/11

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F 157	<p>Continued From page 2</p> <p>21, 2011, revealed "Decrease Lortab to 2.5 mg every 6 hours". Further review of physician's orders dated July 25, 2011, at 3:40 p.m., revealed "Decrease Fentanyl to 25 mcg to be changed every three days; decrease Lortab to 2.5/500 mg every 12 hours; discontinue Cymbalta (antidepressant); continue Symbyax 6/50 mg every evening".</p> <p>Review of the Medication Administration Record (MAR) for July 2011, revealed the Fentanyl 50 mcg was yellowed out to indicate it was discontinued and D/C (discontinue) was written on the line after July 25, 2011. Continued review of the MAR revealed a signature in the 9:00 p.m. space to indicate Fentanyl 50 mcg patch had been applied instead of the new Fentanyl 25 mcg patch as ordered.</p> <p>Review of nursing notes for the month of July 2011, revealed no documentation of notification of the resident's family when medications were changed.</p> <p>Interview with the ADON (Assistant Director of Nursing) on August 23, 2011, at 2:50 p.m., in the conference room revealed there should be documentation in the nurses' notes when a family member is notified. Continued interview revealed the family should be notified any time there is a change with the resident, including changes in medication orders. During further interview the ADON confirmed there was no documentation the resident's family had been notified with each medication change.</p> <p>Interview with the resident's physician on August 23, 2011 at 3:15 p.m. revealed the physician had</p>	F 157			

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F 157	Continued From page 3 not been notified by the facility that the resident had been given the Fentanyl 50 mcg instead of the 25 mcg on July 25, 2011.	F 157			
F 333 SS=D	C/O 28487 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of Emergency Room (ER) records, and interview, the facility failed to prevent a significant medication error for one (#3) of seven residents reviewed.  The findings included:  Medical record review revealed resident #3 was admitted to the facility on July 13, 2011, with diagnoses to include Diabetes Mellitus, Rheumatoid Arthritis, Anemia, Osteoporosis, and Anxiety.  Review of an admission nursing assessment revealed the resident was oriented to person and place; required assistance with transfers, bathing, dressing, and grooming; was continent of bowel and bladder; was independent with eating; and used a rolling walker for ambulation.  Review of transfer/admission orders dated July 13, 2011, revealed the resident was ordered	F 333	F 333 SS=D  <u>Description</u> 483.25(m)(2) Residents Free of Significant Med Errors.  The facility will ensure that residents are free of significant medication errors.  <u>Corrective Action</u> 1. Physician was notified of the medication error by the ADON on 08/23/11. 2. ADON audited the MAR and orders to ensure they were accurate on 8/23/11 and DON and ADON did facility chart audits to ensure other patients were not being affected by this practice on 8/24 thru 8/26. 3. DON and ADON in-serviced nursing staff on 08/24/11 regarding proper procedure for transcribing orders and medication administration during a special called meeting. 4. DON, ADON and weekend supervisor will monitor for compliance during daily chart audits by reviewing new physician orders and occurrences. 100% will be audited for 30 days or until substantial compliance is obtained and will then decrease to 25% for an additional 60 days. DON and ADON will perform medication pass audits with each nurse once every 30 days. 5. Findings will be reported to the QA Committee who will review finding and set new interventions and goals as needed. The QA		

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F 333	<p>Continued From page 4</p> <p>Fentanyl ( narcotic pain reliever) patch 25 mcg (micrograms) to be changed every three days as well as Lortab (pain reliever) 25/500 mg (milligrams) 1 tablet every 4 hours as needed for pain.</p> <p>Review of physician's orders dated July 15, 2011 revealed the resident was ordered Fentanyl patch 50 mcg to be changed every three days. Review of physician's orders dated July 20, 2011, revealed "Lortab 5/325 mg every 4-6 hours as needed". Continued review of physician's orders dated July 21, 2011, revealed "Decrease Lortab to 2.5 mg every 6 hours". Further review of physician's orders dated July 25, 2011, at 3:40 p.m., revealed "Decrease Fentanyl to 25 mcg to be changed every three days; decrease Lortab to 2.5/500 mg every 12 hours; discontinue Cymbalta (antidepressant); continue Symbyax 1/50 mg every evening".</p> <p>Review of the Medication Administration Record (MAR) for July 2011, revealed the Fentanyl 50 mg was yellowed out to indicate it was discontinued and D/C (discontinue) was written on the line after July 25, 2011. Continued review of the MAR revealed a signature in the 9:00 p.m. space to indicate Fentanyl 50 mcg patch had been applied instead of the new Fentanyl 25 mcg patch as ordered.</p> <p>Review of nursing notes dated July 25, 2011, at 3:00 p.m., revealed "Resident alert; able to ambulate without assistance. Complained of pain, relieved by Lortab". Continued review of nursing notes dated July 26, 2011, at 3:53 a.m., revealed the resident was alert and oriented to person, place, and time. Further review of nursing notes</p>	F 333	<p>Committee consist of Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Social, Activities, Food Service Supervisor, RD, Bookkeeping, Payroll, Maintenance and Environmental Services.</p>		09/14/11



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F 333	<p>Continued From page 5</p> <p>dated July 26, 2011, at 9:00 a.m., revealed "Res (resident) transported to ER (Emergency Room) due to alert but no response. Pupils fixed and shaking upper extremities, called res by name, verbally responded, stated ... heard me after that res remained alert but no longer responded". Continued nursing note review revealed 911 (Emergency Services) was called immediately; the physician and family were notified; and the resident was transported to the ER. Further review of nursing notes revealed at this time of transfer the residents vital signs were stable with blood pressure 132/74, pulse 82, and respirations 18 which were consistent with previous vital signs.</p> <p>Review of the ER assessment and report dated July 26, 2011, revealed "Patient found by staff this AM to have decreased LOC (level of consciousness). Was ordered Fentanyl patch 25 mcg but was found with a 50 mcg patch in place. Also noted to have poor cough effort with coarse lung sounds". Continued review of EMT records revealed the resident received Narcan (narcotic antagonist) and became more alert following the administration.</p> <p>Review of the discharge summary dated July 29, 2011, revealed the Fentanyl patch was discontinued and "the patient's mental status returned back to baseline". Continued review of the discharge summary revealed the resident had "bilateral pulmonary infiltrates which were treated with intravenous antibiotics".</p> <p>During interview with the ADON (Assistant Director of Nursing) on August 23, 2011, at 2:50 p.m., in the conference room, the ADON</p>	F 333		

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F 333	Continued From page 6 confirmed the resident received Fentanyl 50 mcg instead of 25 mcg as ordered at 9:00 p.m., on July 25, 2011.	F 333			
F 514 SS=D	C/O 28487 483.75(I)(1) RES RECORDS-COMplete/ACCURATE ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an accessible medical record for one (#2) of seven residents reviewed.  The findings included:  Resident #2 was admitted to the facility with diagnoses to include Colon Cancer and Dementia. There was no medical record available to review. There was a folder with complaint investigation and other miscellaneous papers.	F 514	F 514 SS=D  <u>Description</u> 483.75 (I)(1) Resident Records- Complete/ Accurate/ Accessible  The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete accurately documented; readily accessible; and systematically organized.  <u>Corrective Action</u> 1. Records that are electronically stored were reprinted and placed in the chart for resident # 2. 2. Closed charts will be stored in the medical records office or in the administrator's office with a list of those charts in the medical records office. Closed records removed must be signed out with date time and location. 3. Staff has been in-serviced on guidelines for closed chart storage on 9/15/11 by the Administrator at a scheduled in-service. 4. Administrator, DON, ADON and Medical Records will monitor for compliance during daily rounds by checking sign out sheet to ensure they have been returned. 5. Findings will be reported to the QA Committee for review and needed interventions. The QA Committee consist of Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Social, Activities, Food Service		

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F 514	Continued From page 7 Interview with the Administrator on August 23, 2011, at 1:00 p.m., in the conference room, revealed the chart had been kept in the office of the previous Director of Nursing but the Administrator and Assistant Director of Nursing were unable to locate the record.	F 514	Supervisor, RD, Bookkeeper, Payroll, Maintenance and Environmental Services.		09/15/11